

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003987

EILED VS FEB 1 1 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 1125** STATE FILE NUMBER _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 3 yrs.	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6834a Gravois Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Mary Middle Last Rodefeld	4. DATE OF DEATH Month 1-28-60 Day Year
--	---

5. SEX Female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug 18, 1889	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	---	---	-------------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Ill.	12. CITIZEN OF WHAT COUNTRY USA
---	-----------------------------------	---	---

13a. FATHER'S NAME CATHER Fred Scheveling	13b. MOTHER'S MAIDEN NAME Catherine Scheveling	14. NAME OF HUSBAND OR WIFE --
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Wilbert Rodefeld	Address 6834a Gravois Ave.
---	--	--	--------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pt. Pulmonary Embolus		INTERVAL BETWEEN ONSET AND DEATH new
DUE TO (b) Multiple Deculiti		1 mo.
DUE TO (c) Arteriosclerotic Heart Disease		3 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Intertrochanteric Fract. Left Femur	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
---	---

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Pt. turned over in bed & fell to floor -
---	---	---

20c. TIME OF INJURY 10:05	Hour Month, Day, Year 10/12/59
-------------------------------------	--

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) St. Louis Chronic Hosp. St. Louis	20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Louis Mo.
---	--	---

21. I attended the deceased from 1-31-57 to 1-28-60 and last saw her alive on 1-28-60 Death occurred at 3:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John W. Beckham, M.D.	22b. ADDRESS 5800 Arsenal	22c. DATE SIGNED 1/29/60
--	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/1/60	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) St Louis County Mo.
---	----------------------------	--	---

24. FUNERAL DIRECTOR John L Ziegenhein & Sons 7027 Gravois	25. DATE RECD. BY LOCAL REG. FEB 1 1960	26. REGISTRAR'S SIGNATURE Loel Smith, M.D.
--	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Donald Benning

Licensed Embalmer No. 4963

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.